Attachment 8

Encounter Data Edits

A field indicating an accepted status code or an error code. If the field is in excess of 3 bytes, positions 1-3 are the error code (shown below). Positions 4-5 will show either '00' for an error that occurs in the header portion of the record or a line number from '01' to '15' for an error that occurs in the 15 site locations of the Provider Demographic record. For the purposes of this table, 'nn' denotes the line number.

Note: On the Provider Demographic Record, any of the 15 site location occurrences that are unused must be all spaces.

Valid values are:

- ACCnn - Accepted Record (No errors detected)
- M01nn - Invalid Record Type--Must be V for Provider
- M04nn - Invalid SSN/Tax Code Indicator--Must be S or E
- M05nn - Invalid Action Type--Must be A, D, or R
- M11nn - Invalid Gender--Must be M, F or space
- M12nn - Invalid License State--Must be valid state abbreviation or spaces
- M15nn - Invalid Local Public Fund Indicator--Must be Y, N or space
- M16nn - Invalid Provider Category
- M17nn - Invalid Start Date--Must be valid date, spaces or zeros
- M18nn - Invalid Stop Date--Must be valid date, spaces or zeros or greater than Start Date.
- M19nn - Invalid Missouri Medicaid Provider Indicator--Must be Y, N or space
- M20nn - Invalid Provider Specialty Code--Must be 01, 16,37,44 or spaces
- M24nn - Invalid Association Hospital ID - Must be numeric and greater than zero when any field in the Associated Hospital occurrence is other than spaces
- M28nn - Invalid Established Patient Indicator--Must be Y, N or space
- M30nn - Invalid Number of Enrollees Accepted--Must be numeric and greater than zero
- M32nn - Invalid OB/GYN Accepted Code--Must be 1, 2, 3 or space
- M54nn - Invalid Address Line 1--Must be greater than spaces
- M56nn - Invalid City--Must be greater than spaces
- M58nn - Invalid State--Must be valid state abbreviation
- M60nn - Invalid Zip-Code-5--Must be 5 numeric digits greater than zeros
- M62nn - Invalid Zip-Code-4--Must be 4 numeric digits greater than zeros or spaces
- M64nn - Invalid County Code--Must be a valid county code (See table)
- M66nn - Invalid Phone Number--Must be 10 numeric digits or spaces
- M68nn - Invalid Open Time--Must be greater than zero and less than 2401 or spaces
- M70nn - Invalid Closed Time--Must be greater than zero and less than 2401 or spaces
- M72nn - Invalid Low Age Range--Must be numeric
- M74nn - Invalid High Age Range--Must be numeric
- M78nn - Invalid Language Code--Must be Y, N or space

C-85 Rejection codes (continued)

- M82nn - Invalid New Pregnancy Acceptance Code--Must be Y, N or space
- M98nn - 'Add' Record Type With Active Record Already Om File
- M99nn - Blank Location Segment Followed By Segment With Data
- P01 - No Enrollment Found (Recipient not enrolled with HP)
- P02 - Invalid/Unknown PCP ID (PCP not found in HP member list)
- P03 - Invalid PCP Effective Date
- P04 - Date not in enrollment date range
- P90nn - Invalid Record Key--The provider number must be numeric, the SSN must be numeric and greater than zero, and the provider name must be greater than spaces
- P91nn - Health Plan Provider number not on provider file
- P99nn - Record. Not Found For Replace or Delete

C-85 REJECTION CODES (continued)

The following error codes pertain specifically to encounter claims.
NOTE: Fatal errors are displayed in bold underline print.

V01 - ICN Void Claim Not Found

002 - Fails when the eligibility file shows the recipient is ineligible on the date of service.

005 - Fails when the urovider name keyed does not match the Drovider record for that number.

006 - Fails when the Provider is not eligible on or during the dates of service.

009 - Fails when the recipient name from the claim does not match the name on the eligibility file for recipient ID entered or when the recipient name is not entered or has numeric characters.

013 - Fails when the claim total charge is missing.

015 - Fails when the claim total charge is not equal to the sum of the claim line item charges.

025 - Fails when the attending physician/license number is not present.

034 - Fails when the admission date is missins. not all numeric or not valid.

035 - Fails when the admission date is later than the from date of service.

037 - Fails when admission type code is not Present or is not a valid character.

040 - Falls when type of service 4, 5, ■ ,or H is billed with a place of service 21, 51, 55, 56, or 61. Also fails when type of service 4 or 5 is billed with a place cf service 22, 23, 52, or 62 by any provider type.

041 - Fails when the from date of service is missing, not all numeric or not valid,

043 - Fails when the throush date of service is missins, not all numeric, or invalid.

049 - Fails when the sum of the covered and non-covered days (fields 23 and 24) is not equal to the total days billed (field 52).

053 - Fails when a detail from date of service is missing, not all numeric or not valid.

054 - Fails when the throush date of service is not all numeric or not valid.

057 - Fails when the Inpatient throush date of service is earlier than the from date of service.

060 - Fails when a line item charge is missing, equal ta zero, or has alcha characters.

065 - Fails when a place of service code is not present or not a valid character.

067 - Fails when the type of service/procedure code combination is invalid.

068 - Fails when the national drug code is not on the NDC file.

069 - Fails when the national drug code (NDC) is not present, contains invalid characters, or is not a valid format.

070 - Fails when the quantity dispensed is not present or is not made up of all numeric characters.

072 - Fails when the dispensing date is missins. not all. numeric or not valid.

073 - Fails when the estimated davs supply is missins. not numeric, equal to zero, nesative. greater than 365, or not a 1 on the physician injection drug claims.

078 - Fails when provider bills using a numeric tooth number with a deciduous extraction procedure code.

079 - Fails when provider bills using an alpha tocth number with a permanent extraction procedure code.

080 - Falls when tsoth number is not valid for upper flipper partial.

082 - Fails when tcoth number is not valid for lower flipper partial.

C-85 REJECTION CODES (continued)

086 - Fails when sealant procedure codes are billed with ~.ET & ~ tooth numbers.

108 - Fails when accommodation revenue code is not present or invalid.

132 - Fails when the initial prosthesis placement indicater is not a valid character.

154 - Fails when a diagnosis code for an abortion is billed.

155 - Fails when a procedure code for an abortion is billed.

161 - Fails when denture procedure codes are bill& and LAC prosthesis indicator is blank.

164 - Fails when a tooth number/character is not input or is not a valid value.

165 - Fails when a tooth surface is not a valid value.

169 - Fails when the prescription number is missing.

180 - Fails when the covered days is not equal to the difference between the from and through date. if the patient status is "30" on inpatient claims, the through date is covered.

182 - Fails when the from and through dates are different and the number of units does not equal the number of days that have elapsed.

351 - Fails when another exception has posted to the claim that has been designated as a 'return encounter to health plan', Every claim returned to the health will have exception 351 on it.

352 - Fails when the recipient wasn't 21 on a sterilization surgery date.

355 - Fails when tie **PCP** provider is not a member of the health plan's provider network.

363 - Fails when the encaunter claim dates exceed 60 days for Inpatient and 30 days for Home Health, Outpatient. Dental, Pharmacy and **HCFA-1500.**

365 - Fails when an inpatient claim is billed with zero or non-numeric data in Actual Paid Amount field.

400 - Fails when the Medicare indicator on the claim was marked 'yes', the recipient is older than 65, **or** the eligibility file indicates Medicare coverage for the recipient. The procedure or service must also **be** ccvered by Medicare.

406 - Fails when the recipient eligibility file indicates other insurance coverage and ther is no indication of third party liability on the claim.

410 - Fails when the other insurance indicator is '2' (not applicable) and the recipient has applicable insurance on file.

411 - Fails when the recipient is ineligible for a portion of days within the dates of service.

412 - Fails when the other insurance indicator is '2' (not applicable) and the recipient file indicates no insurance coverage.

434 - Fails when procedure D3220 is billed with a tooth number 01 through 32 or 34.

435 - Fails when procedures D3410 or D3426 are billed with a tooth letter A through U.

458 - Fails when a crisis intervention procedure is billed for a child less than three years of age.

465 - Fails when a diagnosis code is not allowed for the recipient's sex.

466 - Fails when a diagnosis code is not allowed for the recipient's age.

456 - Fails when the recipient is eligible for St. Louis County Genera: Relief.

479 - Fails when a provider bills for a revenue code of 360, 710, or 720, and no surgery date is indicated on the claim.

501 - Fails when a current claim is an exact duplicate of a claim in history or another current claim in the system.

503 - Fails when a current claim is a suspect duplicate of a claim in history, another current claim in the system or fails against duplicate information on the same claim.

510 - Fails when the claim is an exact duplicate to a claim that is currently being Processed.

511 - Fails when a kick payment delivery procedure is billed within 300 days of a previous delivery procedure.

531 - Fails when the billing provider type is 81 and the recipient is not locked into a PHP (Provider type 81) at the time of service.

532 - Fails when the recipient is not a member of the billing health plan but enrolled in some other health plan at the time of service.

542 - Fails when the revenue code on the line item of an outpatient claim is from 300-319 and no lab procedure code is present. Also fails when the procedure code on the line item of an outpatient claim is NOT from 80000-89999 and no revenue code is present.

543 - Fails when no accommodation revenue code is billed on an inpatient claim. but revenue codes 450, 459. 540-549 are billed as ancillaries. The claim should be rebilled as an outpatient claim because Emergency Room and Ambulance Services may *only* be billed as inpatient if the patient was admitted.

576 - Fails when procedure codes Y9500-Y9504 are billed by a health plan.

578 - Fails when the cumber of units billed for procedure code Y9501 is less than 8.

579 - Fails when procedure Y9502 is billed with patient status of '03' or '04'.

700 - Fails when a procedure code is not allowed for a recipient's sex.

702 - Fails when a procedure code is not allowed for a recipient's age.

703 - Fails when a procedure is billed and not dallowed for the place of service entered.

706 - Fails when a procedure code and a diagnosis code conflict.

722 - Fails when a procedure code for an Amalgam, Composite, or Resin restoration is billed and at least one valid tooth surface code and tooth number are not present.

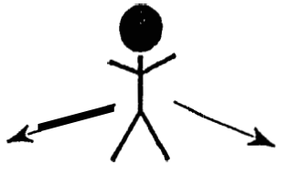
Attachment 9

Complaint and Grievance Procedure

MC+ Complaint & Grievance System

8/16

Members can file with the State and health plan at the same time.
But the State may wait for the plan to look into the problem first.



Health Plan System

COMPLAINT
Informal, 10-days to Answer, Verbal or Written, Filed Within 1-year of Problem, 90 days to Appeal as a Grievance.

GRIEVANCE
Formal, Written, Health Plan Investigates, 30 days to Answer, 90 days to Appeal to Board of Directors

APPEAL
Written, Answer in 60 Days, Hearing Before Board, Plan will Help With Paper Work

Within the State system, members can bypass the informal complaint process.

State System

COMPLAINT
Informal, Verbal, No Time Limit on When to File, No Time Limit on Appeal

GRIEVANCE
Formal, Written, State Will Investigate, No Time Limit on When to File, State May Answer in 30 Days

APPEAL
90 Days to File an Appeal With the State Following Grievance Decision, Written, Hearing before State Hearing Officer

Attachment 9

4/30/98

Comments on the 1115 Protocol

Operational Protocol Guidelines

Page 1, Paragraph 3 - States that the demo project will expand coverage to higher income individuals and/or to provide health care coverage for uninsured working adults without children for a limited geographic area beginning in the second year of the waiver. I do not recall this being in the waiver. If so, what income levels, premium amounts, copayment amounts and geographic area? How will this effect the rates and budget neutrality?

1. Organization and Administration -- This description seems very high level and does not give any specific staffing for the RO to monitor. A more specific staffing including the number of contract compliance officers and quality review nurses, as well as the evaluation staff would be helpful for RO review. Suggest that the names, areas of responsibility and telephone numbers of the persons responsible for the development and oversight of the waiver be provided.

2. This section also does not have the procedures that the State will use for determining adequate managed care capacity by county, as well as the process and criteria for provider selection. These items are required in the Demonstration Terms and Conditions. For example, how will the State determine whether the plans meet the standards listed in the MCO contracts. This section should also list any standards listed in Attachment E of the Demonstration Terms and Conditions and not in the original contracts. How will the State monitor time and distance requirements?

3. Description of Medicaid services --

TANF Transitional Adults for an Additional Two Years Under Title XIX, Uninsured Non-Custodial Parents Below 100 Percent Paying Child Support Under Title XIX, Parents' Fair Share Under Title XIX, Uninsured Custodial Parents Below 100 Percent Paying Child Support Under Title XIX, and Women's Health Services Under Title XIX : These service descriptions are very high level and do not give specific descriptions for the RO to monitor. The descriptions of services should at least meet the requirements of the BBA contracts: The [protocol] should specify which benefits the MCE is responsible for providing or arranging. The [protocol] should include:

- terminology with sufficient precision to determine the extent the MCO will be responsible for providing these services,
- specification regardmg the amount, duration, and scope of *services,*
- list *services* subject to capitation and services otherwise reimbursed- and
- provisions that address the responsibility of the MCO to furnish care and services when medically necessary in sufficient detail to ensure that beneficiaries receive needed services.

page 10, Uninsured Non-Custodial Parents Below 100 Percent Paying Child Support Under Title XIX – In the demonstration application, Missouri stated that "Current

Medicaid budgeting and deduction rules for eligibility will apply to this covered group." However, in the protocol, Missouri states that "Budgeting and deduction for eligibility will be comparabble to current Medicaid rurles for this covered group." Please explain how budgeting and deducation for eligibility will now differ fiom the current Medicaid rules. *Also,* explain how budgeting and deduction for eligibility will differ based on passage of Senate Bill 632.

4. Plan for monitoring coordination of care, utiliion, and payment for out-of-plan services. This description is very high level and does not give any specific monitoring plan for the RO to monitor. A more specific monitoring plan including proposed reports, frequency of monitoring, staffing for the monitoring, criteria for review, etc. should be developed. The Terms and Conditions (C.5.a.) also requires the State to describe how MCOs are *expected* to develop linkage agreements and coordinate care for their beneficiaries with such entities as: public health agencies, school-based health clinics, and family planning clinics The description shall include the process for exchanging patient specific information while protecting the confidentiality of the patient.

5. Please submit an executed copy of the enrollment broker contract to the RO.

Marketing guidelines should at a minimum meet the new BBA requirements:
Contract should specify any restrictions the state places on marketing. These should include (or be consistent with):

- State will prior approve all marketing materials,
- Marketing materials cannot contain false and materially misleading information,
- Plan must market to entire *service* area under contract,
- Plan cannot offer other insurance products as inducement to enroll,
- Plan must not commit marketing fraud and comply with federal requirements for provision of information inciuding accurate oral and written information sufficient for the beneficiary to make an informed decision whether or not to enroll,
- Plan or agents of the plan are prohibited fiom directly or indirectly conducting door-todoor, telephonic or other 'cold-call' marketing.

7. Description of the Enrollment and Disenrollment Process – The confirmation letter should specify that members have a right to change health plans within *90* days from the plan effective date. Please note also that 2.4.2 of the Enrollment Broker RFP incorrectly states that MC+ enrollees have the first 30 calendar days following the effective date of their enrollment to transfer health plans for any reason. The RFP should state 90 days Also please note in 2.2.3, in the 1115 recipients are locked into the health plan for 12 months and 60 days prior to the end of that annual lock-in period the contractor must notify all enrollees informing them of their right to transfer health plans.

Please include the specific parameters of the default assignment process (i.e., how will beneficiaries not choosing a health plan be auto-assigned to plans, including the criteria for dividing the unassigned beneficiaries among plans).

8. This section should also include procedures for obtaining RO model contract approval and the submission of the finalized contracts for validation.

9. Will the EPSDT incentive payment in the Cental Region be extended to the expansion children (Title 21 in years one through three) in years four and five of the demonstration? If not, please describe any applicable incentive payments.

10. Will the same financial reporting and solvency reporting and monitoring requirements from the 1915b apply to the 1115 expansion populations? If not, please describe.

13. The resolution of all complaints and grievances must be accomplished by a date that would allow the state to pursue a fair hearing and assure final decision within the guidelines specified in 42 CFR §43 1.200 et seq.

Items from the draft special terms and conditions not included in Missouri's submitted protocol are noted in bold below.

IV. C.Benefits

3. Pharmacy Benefits - The State shall require that MCOs provide drug formularies equivalent to the standard therapies that were provided in the traditional Medicaid program immediately prior to implementation oiihe demonstration. **In addition, the State shall have in place (and describe in the protocol) a mechanism to monitor the adequacy of an MCO's drug formulary throughout the demonstration. The** State will intervene on behalf of the beneficiary if the beneficiary is having a problem accessing medically necessary drug treatments, due to less than comprehensive MCO drug formularies or underlying restrictive policies. The State shall require that the MCO arrange for providing the necessary drug(s), and that the cost of providing such drug(s) not be borne by the beneficiary. Further, such a problem shall initiate an MCO corrective action plan by the State.

4. Behavioral Health -

a. As part of the protocol, the State must submit a description of the coordination between the MCO and behavioral health providers (including information on how information will be exchanged and how a beneficiary's confidentiality will be protected). **The behavioral health provider information should include C-Star, mental health, substance abuse, and fee-for-service case management at a minimum.**

b. As part of the protocol, the State shall provide **a description detailing how MCOs will meet the requirements for identifying beneficiaries in need of mental health and substance abuse treatment services, In addition,** the protocol must include a description of how monitoring will occur to ensure that MCOs are carrying out their responsibilities.

5. Coordination of Services -

a Linkage Agreements - As part of the protocol, the State must describe how MCOs are expected to develop linkage agreements and coordinate care for their beneficiaries with such entities as: public health agencies, school-based health clinics, and family planning clinics. The description shall include the process for exchanging patient specific information while protecting the confidentiality of the patient.

Access

1. Access Standards -

a. The State must demonstrate that MC+ beneficiaries have an adequate number of accessible facilities, *service* sites, and allied professional services to meet capacity. The State must provide the methodology it is using as part of the plan evaluation and selection process to determine whether each MCO has sufficient capacity. The methodology for conducting this analysis shall be submitted as part of the protocol and should, at a minimum, take into consideration the incidence of providers affiliated with multiple MCOs and the geographic distribution of beneficiaries in relationship to providers, If HCFA decides to run a computer mapping program, the State shall make available (electronically) addressees of demonstration eligibles and providers. (Specific access standards are listed in Attachment E.)

4. Beneficiary Survey - Within 15 months of implementation, the State shall conduct a beneficiary survey of enrollees. The survey shall be generally described in the operational protocol and provided to HCFA for review a minimum of 60 days prior to use. At a minimum, the survey will include such measures as the beneficiary's satisfaction with program administration and the care provided and will include: measures for the use of *emergency* rooms; waiting times for appointments (primary care and specialists); and access to specialty providers. Results of the survey must be provided to HCFA by the 18th month of project implementation. Thereafter, the State shall conduct annual beneficiary surveys. Such surveys shall be designed to produce statistically valid results.

G. Encounter Data Requirements

1. Minimum Data Set - The State shall require (as part of their contract) that all providers submit these data. The State will provide assurances to HCFA that person-level data will be submitted to HCFA or its designated evaluator within 60 days of its request. (The recommended minimum data set is attached - Attachment G.) The State must perform periodic reviews, including annual validation studies, in order to ensure compliance and shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. In the protocol, the State shall submit a minimum data set and a description showing how collection of this encounter data is being implemented,

monitored, and validated as well as how the State will use the encounter data to monitor implementation of the project, set rates, and feed findings directly into program enhancement on a timely basis.